RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO BRODRIGUEZ2@SIMPLYHEALTHCAREPLANS.COM

August 17, 2023

Case No.: 2023012203
File No.: 601000022

Ms. Blanche Fuentes
Contract Manager
Simply Healthcare Plans, Inc.
9250 West Flagler Street, Suite 600
Miami, FL 33174

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Ms. Fuentes:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP068 (Contract), Simply Healthcare Plans, Inc. (Simply) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In January 2023, Simply inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., "[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $2,500 for Simply's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012203 and AHCA File No. 601000022 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

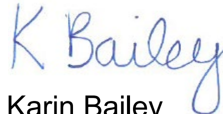
Pursuant to Attachment II, Section XIV.A, Simply "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Simply must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Simply has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Leeanne Peoples, at 850-412-4041 or via email at Leeanne.Peoples@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,



Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Simply may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO BRODRIGUEZ2@SIMPLYHEALTHCAREPLANS.COM

August 17, 2023

Case No.: 2023012208
File No.: 601000022

Ms. Blanche Fuentes
Contract Manager
Simply Healthcare Plans, Inc.
9250 West Flagler Street, Suite 600
Miami, FL 33174

Re: Monetary Sanction for Failure to Comply with Florida Administrative Code (F.A.C.)

Dear Ms. Fuentes:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP068 (Contract), Simply Healthcare Plans, Inc. (Simply) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

Simply paid for services related to the treatment of gender dysphoria for a minor performed by Dr. Sara Danker (Attachment A) in violation of Rule 59G-1.050, F.A.C.

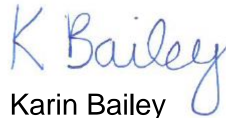
Pursuant to Attachment II, Section II.A, item 3., "[t]he Managed Care Plan shall comply with all provisions of this Contract, including all Attachments, applicable Exhibit(s), and any amendments and shall act in good faith in the performance of these Contract provisions." Pursuant to Attachment II, Section XIII.A, item 2., "[t]he Managed Care Plan agrees that failure to comply with all provisions of this Contract may result in the assessment of sanctions and/or termination of this Contract, in whole or in part, in accordance with Section XIII., Sanctions."

Pursuant to Attachment II, Section XIII.A, "[t]he Managed Care Plan shall comply with all requirements and performance standards set forth in this Contract" and "[i]n the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan…"

Pursuant to Attachment II, Section XIII.F, Simply waives any dispute not raised within twenty-one (21) days of receiving the sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

Please contact your Contract Manager, Leeanne Peoples, at 850-412-4041 or via email at Leeanne.Peoples@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,



Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO WARREN.MOORE@SUNSHINEHEALTH.COM

August 17, 2023

Case No.: 2023012201
File No.: 6

Mr. Warren Moore
Senior Compliance Administrator
Sunshine State Health Plan, Inc.
215 South Monroe Street, Ste. 535
Tallahassee, FL 32301

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Mr. Moore:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP060 (Contract), Sunshine State Health Plan, Inc. (Sunshine) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In December 2022 and January 2023, Sunshine inappropriately paid for prescriptions related to the treatment of gender dysphoria for five (5) minors and one (1) adult (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., "[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed

Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $15,000 for Sunshine's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $15,000 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012201 and AHCA File No. 6 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals

or disputes that are not delivered in the format and timeframes specified by the Agency.

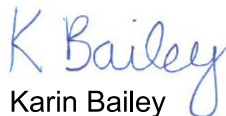
Pursuant to Attachment II, Section XIV.A, Sunshine "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Sunshine must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Sunshine has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Joy Williams, at 850-412-4169 or via email at Joy.Williams@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,



Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Sunshine may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO RQUINTANA3@HUMANA.COM

August 17, 2023

Case No.: 2023012206
File No.: 4

Ms. Rebecca Quintana
Contract Manager
Humana Medical Plan, Inc.
3401 SW 160 Avenue
Miramar, FL 33027

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Ms. Quintana:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP059 (Contract), Humana Medical Plan, Inc. (Humana) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In January 2023, Humana inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., "[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $2,500 for Humana's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012206 and AHCA File No. 4 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

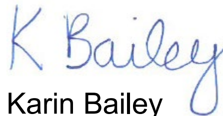
Pursuant to Attachment II, Section XIV.A, Humana "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Humana must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Humana has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Marco Waters, at 850-412-4327 or via email at Marco.Waters@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,



Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Humana may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO HECTOR.FELICIANO@MOLINAHEALTHCARE.COM

August 17, 2023

Case No.: 2023012205
File No.: 5

Mr. Hector Feliciano
VP of Government Contract
Molina Healthcare of Florida, Inc.
8300 NW 33 Street, Suite 300
Doral, FL 33027

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Mr. Feliciano:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP072 (Contract), Molina Healthcare of Florida, Inc. (Molina) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In December 2022, Molina inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., "[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $2,500 for Molina's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012205 and AHCA File No. 5 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

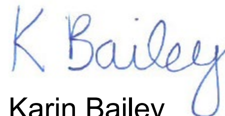
Pursuant to Attachment II, Section XIV.A, Molina "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, Molina must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that Molina has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Marco Waters, at 850-412-4327 or via email at Marco.Waters@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,



Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, Molina may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

SENT VIA EMAIL TO AMIE.BOUNDS@FLHEALTH.GOV

August 18, 2023

Case No.: 2023012200
File No.: 13

Ms. Amie Bounds
Contract Manager
Department of Health
Children's Medical Services Health Plan
4052 Bald Cypress Way, Bin A-06
Tallahassee, Florida 32399

Re: Liquidated Damages for Failure to Comply with Florida Administrative Code and Cease and Desist Further Violations

Dear Ms. Bounds:

Pursuant to Attachment II, Section XV.A.1. of Contract No. FP078 (Contract), the Florida Department of Health Children's Medical Services Health Plan (CMS Plan) is required to comply with all applicable federal and State laws, rules and regulations.

Effective August 21, 2022, Florida Medicaid does not cover the following services for the treatment of gender dysphoria: puberty blockers, hormones and hormone antagonists, sex reassignment surgeries, and any other procedures that alter primary or secondary sexual characteristics. Rule 59G-1.050, General Medicaid Policy, F.A.C. Additionally, for the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), these services do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

In February 2023, CMS Plan inappropriately paid for a prescription related to the treatment of gender dysphoria for a minor (Attachment A) in violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV., "[t]he Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed

Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach."

The Agency is assessing liquidated damages in the amount of $2,500 for CMS Plan's violation of Rule 59G-1.050, F.A.C.

Pursuant to Attachment II, Section XIV.A, "[a]ny liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice." Should the date fall on a weekend or holiday, the payment is due the next business day. Please make the $2,500 check payable to the Agency for Health Care Administration and mail to the following address:

Agency for Health Care Administration
Division of Health Quality Assurance
Enforcement Unit, MS 26
2727 Mahan Drive
Tallahassee, FL 32308

To ensure proper crediting of the payment, please include a copy of this letter with your check and refer to Case No. 2023012200 and AHCA File No. 13 on the check and all correspondence associated with this issue.

Pursuant to Attachment II, Section XIV.A, to dispute the imposition of liquidated damages, "the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute."

The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

- A Managed Care Plan appeal letter that is addressed to the Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed;

- Exhibit A – A copy of the original action letter received from the Agency; and
- Exhibit B – The Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M. EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Managed Care Plan shall make all submissions to the SMMC_CY 18-23 SFTP site (Port 4443) to the folder titled Submissions\Appeals. The dispute file shall be titled ABC_########## where ABC stands for the Managed Care Plan's three (3)-character identifier and ########## stands for the ten (10)-digit case number for the issue being disputed. The Agency will deny any appeals

or disputes that are not delivered in the format and timeframes specified by the Agency.

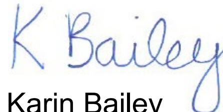
Pursuant to Attachment II, Section XIV.A, CMS Plan "waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue)."

Additionally, CMS Plan must immediately cease and desist from violating Rule 59G-1.050, F.A.C. Further violations will be subject to sanctions under the Contract and will be considered a knowing and willful violation pursuant to Section 409.912(4), Florida Statutes.

Please confirm in writing no later than five days following receipt of this letter that CMS Plan has ceased coverage of the services listed in Rule 59G-1.050, F.A.C., for the treatment of gender dysphoria.[1]

Please contact your Contract Manager, Chanel Smith, at 850-412-4030 or via email at Chanel.Smith@ahca.myflorida.com if you have any questions concerning this matter.

Sincerely,



Karin Bailey
Bureau Chief
Medicaid Plan Management

KB/kb
Enclosure – Attachment A
cc: Alice Wilkins, Bureau of Finance and Accounting

[1] Please note that following a multi-week trial, AHCA was enjoined from applying portions of this rule to the named Plaintiffs in *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-325-RLH (N.D. Fla.). Therefore, the CMS Plan may provide coverage of puberty blockers and cross-sex hormones to the named Plaintiffs in *Dekker* for the treatment of gender dysphoria.